EVALUATION REPORT
ONTARIO FAMILY SUPPORT WORKER PROGRAM

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TABLE OF CONTENTS

I. SUMMARY OF FINDINGS 1

II. BACKGROUND 3

III. THE PROGRAM EVALUATION - ORIGINS AND METHODOLOGY 5

IV. RESULTS OF THE EVALUATION

1) **Organizational Structure, Climate Objectives** 6
   - A) Worker - Agency Impact 7
   - B) Reporting Relationships 7
   - C) Agency Influence on Program 8
   - D) Provincial Policy 8
   - E) Agency F.S.W. Program Objectives 8

2) **Implementation of the Family Support Programs**
   - A) The Provincial Level 9
   - B) The Indivudual Program Level 9

3) **The Family Support Workers**
   - A) Self-Definition 11
   - B) Program Components 11
   - C) Evaluation and Supervision 13
   - D) Operating Procedures and Caseload Characteristics 14
   - E) Work Histories, Training, Salaries 16

4) **Client Characteristics and Client Impact**
   - A) Methodology 17
   - B) Findings 17
   - C) Client Impact 19

5) **Impact on Service Coordination** 21

V. FOOTNOTES 23

VI. APPENDIX
   1) Client Survey 24
   2) Client/Case Description 34
   3) Community Agency Servey 40

I. SUMMARY OF FINDINGS

A. THE NATURE AND CHARACTERISTICS OF THE HOST ORGANIZATION HAVE MAJOR EFFECTS ON INDIVIDUAL FAMILY SUPPORT WORKER PROGRAMS. FOR EXAMPLE:

- O FAMILY SUPPORT WORKERS AFFILIATED WITH THE LARGER, MULTI SERVICE ORGANIZATIONS TEND TO CONCENTRATE ON PROVIDING DIRECT SERVICES TO THE HOST ORGANIZATION'S CLIENTS AND TO UTILIZE MOSTLY THE INTERNAL SERVICES OF THE HOST ORGANIZATION WHEN SERVICE COORDINATION IS NEEDED.

- O SMALLER, AUTONOMOUS PROGRAMS TEND TO CONCENTRATE MORE ON FINDING AND COORDINATING EXTERNAL COMMUNITY SERVICES, AND AS A RESULT THEY TEND TO UTILIZE MORE GENERIC SERVICES AND TO PERFORM MORE CASE AND SYSTEMS ADVOCACY.

B. THE LACK OF AN ACTIVE, STAGED OR PLANNED IMPLEMENTATION OF THE PROGRAM BY BOTH THE MINISTRY AND MOST CONTRACTED ORGANIZATIONS HAS LED TO A DIVERSITY OF PROGRAM OBJECTIVES AND A LACK OF INDICATORS OR TIME FRAMES WITH WHICH TO EVALUATE OR MEASURE ACHIEVEMENTS.

C. THERE IS A WIDE GAP BETWEEN THE APPARENT GOVERNMENT EXPECTATIONS (POLICY ORIGINS) FOR THE FAMILY SUPPORT WORKER PROGRAM AND THE ACTUAL PRACTICES OCCURRING FOR EXAMPLE:

- O ONLY ABOUT HALF OF 112 CHILDREN REVIEWED IN 93 SAMPLE FILES HAD ANY DOCUMENTATION IN THEIR FILE INDICATING THE PRESENCE OF SOME FORM OR DEGREE OF MENTAL RETARDATION. THIS MAY BE EXPLAINED BY THE APPROPRIATE INCLUSION IN CASELOADS OF CHILDREN WHO HAVE DEVELOPMENTAL AS WELL AS OTHER PRESENTING PROBLEMS.

- O FEW OF THE INTENDED COMPONENTS OF THE FAMILY SUPPORT WORKER ROLE (ASSESSMENT/DIAGNOSIS, I.P.P., COORDINATION OF SERVICE, ADVOCACY, ETC.) ARE APPARENTLY BEING CARRIED OUT AT THE LEVEL OR IN THE MANNER ANTICIPATED. FAMILY SUPPORT WORKERS TEND TO BE INVOLVED IN IMMEDIATE PROBLEM RESOLUTION AND FAMILLY STABILIZATION RATHER THAN FUTURE DIRECTED PLANNING AND SERVICE COORDINATION. MOST OF THE EXAMPLES OF CASE MANAGEMENT PRACTICE ARE CONCENTRATED IN A FEW AGENCIES.

- O IN PARTICULAR, THE LEVEL OF PROGRAM ACTIVITY FOR THE MENTALLY RETARDED CLIENT AND FAMILY BY COMMUNITY BASED GENERIC SERVICES DOES NOT APPEAR HIGH, NOR IS IT INCREASING SIGNIFICANTLY AS A RESULT OF THE FAMILY SUPPORT WORKER PROGRAM.

- O LOCATING OR ARRANGING ALTERNATIVE RESIDENTIAL PLACEMENTS WAS A MAJOR CONCERN FOR FAMILY SUPPORT WORKERS WITH A DIRECT SERVICE ORIENTATION.

D. OF THE 100 'RELATED AGENCY' WORKERS INTERVIEWED, VERY FEW APPEARED TO UNDERSTAND THE DESIGNATED ROLE OF THE FAMILY SUPPORT WORKER. FEW RELATED AGENCY WORKERS INDICATED ANY PHILOSOPHICAL OR POLICY-RELATED CHANGES OR EFFECTS IN THEIR OWN AGENCY OR IN THEIR ORGANIZATIONS' SPECIFIC OPERATIONS AS A RESULT OF THE FAMILY SUPPORT WORKER. THEY DID, HOWEVER, SEE THE FAMILY SUPPORT WORKER AS HAVING A POSITIVE IMPACT ON CLIENTS.

E. THERE IS A HIGH LEVEL OF CLIENT SATISFACTION ABOUT THE FAMILY SUPPORT WORKER PROGRAM. CLIENT PARENTS APPRECIATED THE WORKERS' DEMONSTRATION OF PERSONAL COMMITMENT AND SUPPORT. SATISFACTION IS ALSO REFLECTED IN THAT A HIGH PROPORTION OF CLIENT FAMILIES (53%) IDENTIFIED THE FAMILY SYPPORT WORKER AS THE PERSON TO WHOM THEY WOULD FIRST TURN FOR HELP IN THE EVENT OF NEW NEEDS OR PROBLEMS. THE FAMILY SUPPORT WORKER IS SEEN AS A 'DOER'.

F. IN THE SAMPLE GROUP OF PROGRAMS STUDIED THE SIXTEEN FAMILY SUPPORT WORKERS WERE A MATURE AND QUALIFIED GROUP WITH, IN MOST CASES, A SUBSTANTIAL RELATED BACKGROUND AND A STABLE PERIOD IN THEIR CURRENT POSITION. TURNOVER GENERALLY WAS LOW COMPARED TO SIMILAR SOCIAL SERVICES PROGRAMS.

II. BACKGROUND

The policy origins of the Ontario Family Support Worker Program trace to the early 1970's. At that time The Williston Report [1] (1971) regarding care and services to mentally retarded people in Ontario was followed and supported by a government Green Paper [2] (1973) which centred around the concept of 'community living'. The Developmental Services Act of 1974 then provided for the transfer of services for mentally retarded people from the Ministry of Health to the Ministry of Community and Social Services. At the same time the Act allowed for the provision and funding of new services in the community and subsequently in April of 1975 the Ministry published detailed program proposals and implementation plans to effect the "principle of the Community living thrust" [3]. It is important to note that these more operational proposals and plans on the part of government were evidently the result of early developments in two areas:

- the pioneer programming in case management and individual treatment planning that had developed in the 1960's in specialized facilities like Surry Place Centre (Toronto)

- the push for and experience with community-based, family-oriented support programming which grew in local Associations for the Mentally Retarded in Ontario throughout the 1960's and 70's.

The government's 1975 program proposals were described in three areas: Accommodation Programs, Work and Training Programs, and Support Services Programs. The major purpose of the Support Services Program area was "to make available to retarded people necessary support and protection, enabling them to utilize the generic services available in the community as well as any other special service needs which are required." "Family Services" joined "Adult Protective" and "Life Skills" services as one of three key components of the Support Services Program area, and the role of Family Service Workers (now called Family Support Workers) was first described in the 1975 document. It was anticipated that they would:

- Provide supportive services to families with retarded persons, concentrating on families of retarded children

- counsel both families and children

- refer to and coordinate appropriate community services

- perform case management, client advocacy and case finding roles.

The family Service Worker was to play a key preventative role by assisting in early detection of mental retardation and ensuring that everything possible was done "to help reduce the severity of its effects". It was projected that with adequate support and the provision of needed services the families of children up to age twenty, who historically accounted for about eighty-four percent of all admissions to the large institutions, would no longer find it necessary to place their children outside the home.

The emphasis for all the community services programs in 1975/6 was to be on the need of individuals, and consequently Individual Program Plans (I.P.P.s) were to be developed for every retarded person requiring services. Evaluation of the full program was expected to be linked to the development and progress of the mentally retarded individuals throughout the new system and this development in turn was to be measured using I.P.P.s. A standardized system for recording individuals' needs and progress in the I.P.P. was therefore anticipated to enable program and service evaluation as well as projection of local service needs.

The first new Family Service Worker programs in Ontario were actually transformations or relocations of existing institutional services. Some institutional social workers were reassigned to the new family service/support function and several existing case management programs which were already focussed on mentally retarded children were newly regarded as Support Services Programs. This was true for some facilities for the mentally retarded and several Children's Aid Societies. The development period from 1975 to 1977 also saw resources supporting new support service programs in five Associations for the Mentally Retarded peripheral to Metropolitan Toronto [4] -- however, operating guidelines for these programs had not been developed by government. Resourcing was subsequently withdrawn from one agency by 1977, when the distinctive functions and components of the family service programs were not discernable from other social caework programming.

In 1978 shortly after the formation of the Children's Services Division of the Ministry of Community and Social Services, a number of Toronto voluntary human service organizations contracted to deliver Family Service Programs for mentally retarded clients and families. The organizations' executives had been drawn together at the initiative of government program advisors, as they favoured generic agency interest, and the agencies represented a considerable range in size and types of social service programs. Beginning in 1978 other Ontario voluntary organizations (Walkerton, Oakville, Peel and Thunder Bay) contracted to deliver Family Support Programs, and many of them reported that they were responding to the prevention policy thrust of the new government Children's Services Division. With this in mind it is notable that some were resourced and labelled as 'case manaagement' programs due to Ministry funding restrictions on Family Support Worker programs in 1978 and 1979.

By 1980 the Ministry of Community and Social Services listed over thirty organizations across Ontario that were contracted to deliver Family Support Worker Programs. In 1982 these programs now employ about fifty professionals with a wide range of backgrounds that are comparable to the variation in the missions and operating characteristics of the sponsoring agencies.

III. THE PROGRAM EVALUATION - ORIGINS AND METHODOLOGY

The 1981 decision by the Ministry to evaluate its provincial Family Support Worker Program came in the context of a number of related policy projects. There was of course an historical provincial commitment to evaluate this program. In addition the Family Support Worker Program's congruence with its original policy objectives was not well documented. At the same time, Ministry planners have been studying models and reports of case management and case and class advocacy. Consequently the Ontario Family Support Worker Program evaluation is one means of identifying the actual operating components and the benefits of case management practice and client advocacy. This report is part of a larger review of key components of case management and their current or potential application in a wider spectrum of children's services (Key Elements of a Family Support/Case Management Model, Applied Research Consulting House, 1982[5]).

The evaluation of Ontario Family Support Worker programs was carried out using a sample of seven host organizations (Table 1) that were both as diverse, and as representative as possible of the total group of thirty host organizations. The selection was made by an expert panel of professionals and program specialists. Size, mission, and location were the features considered in the selection by the Ministry of the seven organizations for study. Also Surrey Place Centre (a Ministry operated facility) was included in the sample because of its unique and specialized program and its long experience with case management.

The evaluators were not examining the quality or impact of individual Family Support Workers or their programs. Rather the focus was on the role, functions, and professional interactions of the Family Support Workers. Because multiple perspectives are important, the evaluation sought information on these general topics from not only the workers but also their supervisors, agency directors, in-house colleagues, other agency professionals and client families themselves. Ninety-three representative case files were examined for documentation and component indicators related to the Family Support Worker's role (cf Appendix: Client/Case Description; p.34). Rather than ramdom sampling, evaluators asked each agency Family Support Worker to present fifteen files that she thought best represented the mix of clients she had worked with over the past several years. The files were therefore subjectively mixed for variables such as age and level of functioning of client, status of family, case status, multi-problem or multi-agency dynamics. Telephone interviews, set up and introduced by letter or phone (often both), were conducted with eighty four parents of the ninety-three cases mentioned above. These interviews were based upon a consistent format and were reviewed and summarized using the survey instrument (cf Appendix: Client Survey; p.24). Finally one hundred telephone interviews which involved other agency (workers) ... both generic and MR specific, referral and service ... were conducted (cf Appendix Community Agency Survey; p.40). In addition Family Support Worker program documents were reviewed and these included, for example, logs, quarterly reports, staff time sheets, previous evaluations, brochures, job descriptions, minutes of staff meetings, training events, policies, standard procedures, correspondence, and records of publicity.

In summary, the evaluative approach to the provincial Family Support Worker Program sought and obtained both qualititative and quantitative data on policy related factors.

IV. RESULTS OF THE EVALUATION

Rather than systematically present the data from the various sources outlined above, these 'Results' represent an integration of the survey data, file reviews, and personal interviews. The Appendix contains the detailed results of the....

- **Client Survey administered to eighty-four clients**
- **Client/Case Description based on the file information of the interviewed clients**
- **Community Agency Survey conducted with one hundred related workers**

References are made to these Appendices throughout this 'Results' section.

1. ORGANIZATIONAL STRUCTURE, CLIMATE, OBJECTIVES

The evaluation studied the Family Support Worker Programs in seven quite different organizations. As anticipated by a previous report [6] it found that the nature and characteristics of the host organization exerted a considerable influence on individual Family Support Worker programs. Table 1 introduces the diversity and lists some of the organizational variables identified in the evaluation.

TABLE 1

AGENCY AND LOCATION (PGM./WORKER TITLE)	SIZE AND TYPE OF AGENCY	ORIENTATION OF FAMILY SUPPORT WORKER PROGRAM
Childrens' Aid Society of Metropolitan Toronto (Family Support Worker Program/ Family Support Worker) Toronto	large, multi-service, child welfare agency, mandated by legislation to protect and care for certain children. Has Family Services and Children's Services functions.	- provides direct services only to families on caseload of C.A.S. Family Services Worker. - an 'internal' service.
City Social Services Department (Family Service Worker Program/ Family Service Worker) Thunder Bay	medium-sized, municipality-operated social services; emphasis on family benefits administration (mandated); has parent-child program	- provides service mainly to Departments clients - emphasis on direct service
Dalhousie Community Service Centre (Family Support and Enrichment Program/ Family Service Worker) Ottawa	medium-sized, multi-service centre; partnership funded (Com Soc, Health, municipality). Centre contains workers seconded from C.A.S., Public Health, Social Services, etc.	- provides service mainly to service centre clients - emphasis on direct service
Huntley Youth Services (Family Support Worker Program/ Family Support Worker) Toronto	small multi-service association providing a range of generic services to troubled youth and their families.	- intake from the community intake system of the organization... limited internal service. - service type mostly coordination
Sheridan College of Applied Arts and Technology (Halton Region Case Management Service/ Family Support Worker) Oakville	medium-sized college with small MR Services program being the only non-educational service provided. MR Services include A.P.S.W.	- service to community clients - strong emphasis on case coordination function - direct service minimal
Surrey Place Centre Ministry of Community and Social Services (Case Management/ Case Coordinator) Toronto	large, specialized, direct-operated program. Case Management department is key coordinator of nearly 1000 cases.	- all are community cases through central intake. - direct service only as necessary and very limited; emphasis on case coordination both 'in house' and external
Walkerton and District Association for the Mentally Retarded (Family Support Services Program/ Family Case Management Worker) Walkerton	small, multi-service association providing specialized services to handicapped persons and their families	- intake from the District (community) and service to this group. - emphasis on service coordination

A. Worker-Agency Impact

Foremost among organizational characteristics which affected the Family Support Worker Program was the multi-service aspect of the larger, comprehensive and mandated organizations. These larger organizations tended to emphasize the provision of direct services to families. When Child Welfare authority or family benefits administration were juxtaposed with this service delivery orientation the Family Support Workers also tended to play a role in crisis support to families. The evaluation revealed that for these same larger organizations new program development or outer-directed initiatives in their local communities were minimal. By contrast the smaller organizations in the sample were more likely to emphasize case coordination. In these agencies there were examples of internal attitude changes on the part of other program staff, and new program development in the community. An integrated day care program, behaviour management programming, and recreation and integrated grooming groups are examples.

B. Reporting Relationships

As would be anticipated, Family Support Workers in the smaller agencies tended to report to the agency Director, and to have a clear line of responsibility and active communication about the support program. However, several of the larger generic multi-service organizations that were studied tended to have complex and variable reporting relationships for Family Service Workers. For example, evaluators found one Family Support Worker under the general supervision of an Adult Services Coordinator who reported to the Department Administrator. Meanwhile as a social worker, this same Family Support Worker reported to a Supervisor of Social Workers. There was some confusion among co-workers about the function and scope of activities of this Family Support Worker and the wide mandate of the organization appeared to encourage further confusion about whether the Family Service Worker works only with mentally retarded persons and their families. Similar misunderstanding and lack of co-worker knowledge has held the caseloads well under capacity in another large agency. Professional colleagues in related family service functions were reported to turnover at a rate of up to forty percent annually. Thus as a group they have tended not to be familiar enough with the Family Support worker to keep her caseload filled. One multi-service generic centre had a deficit of supervisory structure and experience, and Family Service Workers there were themselves confused about appropriate referrals, clients to be served, their role with families, and interaction with other professionals in their agency. Here a complex internal structural environment was complicated by some staff being seconded from other agencies reporting laterally, and knowling little if anyting about the Family Support Worker program.

C. Agency Influence on Program

The host agency environment was clearly the key local environmental influence in the provincial Family Support Worker Program. In the absence of clearly communicated policy and program expectations from the government, individual Family Support Worker programs have been characterized by the unique needs and policies of their host agencies. The larger multi-service or multi-program centres, for example, used the Family Service Worker to coordinate internal cases with the various programs indigenous of the agency. These same support programs tended also to deliver more direct services to internal cases and perform fewer case coordination, advocacy, or educational functions in the community. This 'internal service-provider' role may have partly reflected the fact that Family Support Worker salaries were in many cases lower than those of comparable positions in the same organization, (not true for Case Coordinators at Surry Place Centre). The evaluation saw only a little evidence in the program as a whole of generic program changes, or changes in philosophy brought about by Family Support Workers influencing their colleagues.

D. Provincial Policy

As alluded to above, there has been an absence of strong and consistent government policy leadership of the Family Support Worker Program since its inception. The Community Resources Branch funded original programs in 1975 without clear expectations and eventually had to withdraw support of some agencies on account of the application of the resources to traditional social services models. This was not intended, and in 1977 the Branch developed the two page Family Support Worker Program Description (7) as the first and only guide for service delivery organizations and workers. For these reasons the program is perceived by some ministry officials and by some informed Directors of generic service agencies as a "hybrid". This is reportedly because of differences in "pre and post (1977) guidelines" programs, as well as the lack of accountability or supervision toward the implementation of government support services policy.

E. Agency F.S.W. Program Objectives

Within the Family Support Worker host organizations themselves, policy development and its translation of programming is again diverse. While the evaluation found that all host agencies had some documented policies and procedures related to the Family Support Worker, the basic conceptions underlying them were wide ranging. For example, the client group was "children at risk" in several programs. Some programs were confused about degree of family focus and files were seen that were totally family focussed with no indication of a handicapped child. Prevention was interpreted as a goal for family support in one program and the problem of balancing service coordination with direct service delivery was evident in another agency's policy. Certainly each of the

programs studied had one or more of the Ministry's original (1975) program objectives (as listed on page 3). The evaluation found that written objectives were not usually specific and seemed more like 'mission statements'. Measurable objectives were rare. Example objectives seen by or reported to evaluators were "to identify and assess family situations...,'to serve a chronic population...,'to maintain communication...'to visit client...,'to evaluate the effectiveness of program goals'. Few of the programs had written indicators to measure achievement of objectives such as client visitation, generic agency contacts, or family assessments. One program that did have such indicators had built in and operated an annual procedure for revising objectives. The indicators of achievement in this case were mostly measurable (e.g. number of client contacts, number of referals from/to generic agencies per time unit, etc.). This same program had a strong case coordination orientation.

2. IMPLEMENTATION OF THE FAMILY SUPPORT PROGRAM

A. The Provincial Level

From its inception, the Family Support Worker Program does not appear to have benefited from a staged implementation plan at the Provincial level. Although the ambitions for evaluating the program were identified in 1975[8] there appears to have been little central review or accountability. The intentions outlined in that document identified that the Individual Program Plans (IPP) would constitute the basis of both a case and program evaluation. Much of the program's planning seems to have been verbal and on an ad hoc basis. An outline of program objectives was available only in 1977,[7] some time after many programs were in fact implemented.

There was only one occasion that evaluatiors have been able to identify when the Directors of various programs actually met together to discuss common issues and concerns. Ministry officials were generally aware of the nature and status of individual programs, but did not appear to play a major role in the planning or implementation of individual programs. There is some ambiguity as to whether their role is advisory or supervisory and while there are examples of Ministry officials in certain areas conducting ongoing meetings with the Family Support Workers, this is the exception. In at least one area, the Family Support Workers have initiated regular meetings to discuss common issues with their counterparts (other Family Support Workers) in neighbouring agencies.

B. The Individual Program Level

Most of the individual programs had some type of implementation plan for their particular Family Support Program. However, these varied widely in terms of their sophistication and effectiveness. Well developed implementation plans were the exception. In addition, not all the plans which were developed were actually carried out.

Generally, the programs which had a stronger community/service case coordination orientation (vs. an internal/direct service orientation), engaged in a more extensive and effective implementation process. For example, one agency with a strong case coordination orientation set out to systematically visit, and introduce its entire staff to a broad range of generic and special service agencies in the community. In addition to introducing and describing their case management services to these agencies, workers also used the occasion to learn more about each service agency and to establish personal links that could be used later. The process extended over several months and was a source of some of the program's initial referrals. The Family Support Worker program referred to has continued its outreach activity by distributing flyers, joining relevant community committees, arranging for media coverage and generally doing what they can to maintain the profile of the services in the community. Most recently, they have developed the first Directory of Community Resources available in the area, thereby facilitating their own activities, as well as contributing to their image as case coordinators.

At the other end of the spectrum is an example of a more direct service-oriented program that obtains referrals exclusively from its host organization. It also has the smallest caseload of all those surveyed in this study. Because the host organization is a large one and has a high turnover rate among workers who are potential referral sources for the Family Support Program, the program has had difficulty maintaining a high profile among its internal referral source. The program does not advertise itself outside of the host organization. Implementation originally consisted of an internal announcement of the program's existence and more recently introduction at team staff meetings.

The implementation process in other organizations ranged widely. In one case the initial worker in a program was extremely well known in the area and implemented the program through her network of personal contacts. In another case, the family support activities of the agency predated the development of the Family Support Worker Program and no new implementation plans were required.

In general, the type and extent of the implementation process was most strongly influenced by the philosophy and orientation of the host organization. Host organizations with stronger community/service case coordination objectives engaged in more extensive implementation activities. Those with a stronger direct service/internal client orientation were more likely to simply make an internal announcement.

All programs received at least some initial referrals from their host organizations. Programs with a service coordination objective began seeing clients outside of their host agency after some months. Programs with a direct service objective generally increased the range of services to clients already involved with the host organizations.

3. THE FAMILY SUPPORT WORKERS

A. Self-Definition

The evaluators interviewed a total of sixteen Family Support Workers in seven sample agencies, and were struck by the variations among them in their views of their own role. Their array of titles - Family Service Worker, Case Coordinator, Family Case Management Worker, Case Manager, Family Support Worker, etc.-- is a first indication of likely role variations. Workers described themselves in a variety of terms. Interviewers heard that among others they were "educators", "service providers", "counsellors", and "community developers". What was particularly interesting was that virtually none of the workers interviewed, when asked about the goals, objectives and day-to-day components of her job, listed the model components set out in the Ministry's 1977 Family Support Worker program description. It should be noted that several supervisors or agency Directors did list these components accurately and that many Family Suport Workers mentioned individual components...most frequently "service delivery coordination". 'Individual Program Plan' development was also frequently mentioned but in many cases it was mentioned by the Family Support Worker while discussing case management or other topics. The principal finding from this is not that Family Support Workers don't carry out some of the functions anticipated by provincial policy, but that they apparently have not been involved in any detailed goal setting and role assessment based on apparent Ministry policy expectations. A review of the Family support Worker's anticipated (by policy) and actual functions and responsibilities develops this theme in the following section.

B. Program Components

It has already beed mentioned above that the evaluation concerned a sample of seven diverse organizations each with a unique Family Support Worker program. However it is possible, for the purposes of this evaluation, to select some common job components and functions of Family Support Workers and place them on a simple continuum (Table 2) related to their host organizations. The activities of Family Support Workers which are most common and emphasized in all types of host organization are located in the centre of the continuum. The 'end point' job components tend to be associated with particular types of organizations and programs.

TABLE 2

EXAMPLE JOB COMPONENTS AND FUNCTIONS OF FAMILY SUPPORT WORKERS

PARENT TRAINING (PARENTING SKILLS, INFANT STIMULATION, BEHAVIOUR MANAGEMENT, ETC.)	COUNSELLING PARENTS, FAMILIES	SUPPORTING PARENTS	ASSESSMENT OF CLIENTS NEEDS	COORDINATING SERVICES	EDUCATING PARENTS ABOUT SERVICES; SELF HELP, CONSUMER ACTIVISM	ADVOCACY	COMMUNITY DEVELOPMENT

DIRECT SERVICE ORIENTED PROGRAMS, CHILDREN CONSIDERED "AT RISK", "DEVELOPMENTALLY DELAYED" MORE CRISIS-ORIENTED

COORDINATIVE SUPPORT PROGRAMS -CHILDREN "MODERATELY OR SEVERELY MENTALLY RETARDED"

Initial home visits for purposes of contact and assessment was a common activity reported by almost all workers for all new cases. In only one agency was this assessment or diagnostic component regularly carried out in the workers' offices. All others preferred the client's family home. Document review in this evaluation reveal variable comprehensiveness in 'the diagnostic component' (assessment of needs). Most programs in the sample had no explicit framework for collecting information during assessment. One agency utilized a form, but this was used loosely in the file samples reviewed. Client and worker surveys plus file reviews produced the clear finding that the needs expressed by client families are used to define the content of most needs assessments in the Ontario Family Support Worker program (items: 2, p.24/14, p.30/9, p.37/10, p.44). Direct observation by the Family Support Worker during initial visits supplements these needs. In some cases this process was supplemented further by the collection of previous assessments and/or the results of case conferences with other agency staff.

The provincial Family Support Worker Program description expects goals and objectives to be related directly to the priorized 'needs' or diagnostic factors determined in assessment. With "input from the client and/or relevant agencies" they are to be reflected in an **individual program (or treatment) plan (IPP).**

A large majority of client parents interviewed had no knowledge of a written Individual Program Plan related to their child and/or family (item 8, p.37. Few had any sense of long term planning being done by their worker. It should be noted that Family Support Workers reported that in some cases their failure to share plans with parents was deliberate because of the actual goals (e.g. 'help parents accept child's retardation'). Still, the review of ninety three case files indicated that the use and importance of the plans and a planning process was limited. The IPP's were found to be more general and non-specific than expected by the Ministry's Detailed Program Proposal (1975)[3], and suggested by literature on individual program planning and case management in general (item 7, p.36).

Direct service delivery and **service delivery coordination** are the two principal activities of Ontario's Family Support Workers. The program evaluators used a number of basic characteristics of service coordination with which to compare the findings related to coordination in the Ontario Family Support Worker Program. For example, the service coordinator should have a self-perception that she is performing this function. She should obtain and maintain contacts with key agencies or individuals related to her clients, and in this respect should be perceived by these agencies and individuals as the case coordinator. The client also should see the Family Support Worker as the prime worker or the coordinator of services, and it should be evident that the worker overviews and plans for current and future client needs. In some instances coordination is facilitated by a legal mandate carried by the worker and/or the ability of the coordinator to purchase services (eg. child welfare).

Several of the programs observed were almost exclusively direct service delivery programs. In its extreme, this model is well exemplified by the role of the Family Support Worker in a multi-service, child welfare agency. The caseload here ranges from eight to fifteen and the Family Support Worker's principal activity is 'in home training, assistance and support for multi-problem families'. Case coordination is usually left with the authorized Family Service Social Worker in the same agency. In the sample organizations studied the degrees of direct service delivery ranged considerably but overall there was more being done than expected (items: 1 & 2 p.24/9, p.37/13, p.39/10, p.45). Several Family Support Workers accounted for this by explaining the breadth of their mandate to provide support services. "The buck stops here", one said. Counselling, regular weekly or bi-weekly visits, behaviour management and other training in the home, and transportation assistance were the main direct service activities.

Most Family Support Workers, as reported above, somehow indicated that 'service delivery coordination' was a principal component of their role. The prominence of this role function, however, was not suported by the results of client interviews, other related agency (worker) interviews, or file documentation (items: 1 & 2, p.24/7 p.36/9, p.37/12, p.38/13, p.39/3 & 5. p. 41/6, p.42). Clients tended to see the workers as 'providing' or 'finding' services. Moreover case-related agency professionals tended to describe the Family Support Worker as a support service, with the emphasis on service. The identification of **'gaps in service'** as a function, evolves from difficulties in service coordination, and it was mentioned by only a small number of Family Support Workers as one of their role components. Some workers who didn't initially mention this function explained that it was a 'taken for granted', 'obvious' concomitant of service coordination ("Of course we identify gaps!") and this may account for its low prominence in interviews. However, the related **advocacy role** which was anticipated by the original Ministry policies was similarly under-reported by Family Support Workers. In fact, apparently only one program has advocacy as a written objective. In most cases it was not a clearly defined role, and when it was discussed in interviews many workers often did not demonstrate a clear understanding of what was inherent in the concept. Nevertheless, there were examples of advocacy in each of the sample programs, as well as several anecdotes about more substantial advocacies that had worked significant benefits. However, files and documents, other agencies, and clients provided only limited evidence that advocacy is an active component of Ontario's Family Support Worker Program.

C. Evaluation and Supervision

The review of files and documents, and interviews generally provided little evidence that program evaluation had been carried out in individual programs. In only one case was an internal program evaluation conducted soliciting feedback from clients and community agencies by survey. In

particular the anticipated use of the Individual Program Plan as an evaluative tool was not observed. Most Family Support Worker programs were supervised regularly by designated professionals and these supervisors usually worked in close proximity to the Family Support Worker. Their meetings ranged from one to every three weeks and supervision reportedly focused on case and related problems. Review of individual program plans and regular client planning generally were not mentioned as ingredients of supervision sessions, but most workers spoke favourably about the usefulness of their supervision.

D. Operating Procedures and Caseload Characteristics

The evaluation found wide variation in **caseload** sizes across the seven programs studied. Total cases being served per organization (excepting Surrey Place Centre) including active and follow-up ranged from eight in the one organization, to about twenty in two organizations, fifty or sixty in two other remaining agencies and one hundred in a final agency.

There was generally a lack of clear case status designation ('active', 'follow up', or other) in the files studied and consequently a lack of clarity about the Family Support Worker's level of involvement with families and clients. All the programs reviewed did report some form of case classification ranging from a two to a five point system. While the two point systems were of the form 'active/follow up' or 'active/closed' the wider systems used priority ratings based on level of need or amount of worker time required. But clear indicators of the case status in files examined were not observed. Several programs did not employ a classification or criteria for case closure, and their clients technically did not 'exit' the service system. In the Toronto area a five point system based on frequency of contact is used by all Family Support Workers to collect city-wide statistics. However, it was reported that this procedure was not being consistently and effectively used and that its reliability was in doubt when some workers could manage only a maximum of ten to fifteen cases in a very active category while others reported twenty-five or thirty. Across the seven programs, active cases were reported to comprise from twenty to eight-five per cent of total caseloads, and cases per worker ranged fully from about eight to forty.

The above variations in caseload data and characteristics make it evident that Family Support Workers' day to day **operating procedures** varied considerably. In general the most frequent types of client contacts by the Family Support Worker were home visits, telephone calls, program visits and parent groups. The following describe in more detail the nature and frequency of each:

a) HOME VISITS - All the Family Support Worker programs used home visits for most cases, at least for initial assesment purposes. Existing evidence indicated that the home visit remained particularly important for those programs servicing younger children. In those cases the Family Support Workers provided supportive counselling and, in some programs, one to one programming with the child. Home visits ranged from about one hour minimally to between three and five hours (especially in those programs where the Family Spport Worker provided much direct counselling and work with the child).

b) TELEPHONE CONTACTS - During periods of more intensive involvement with a family, the Family Support Worker made frequent telephone contact. In the early phases of managing cases the purposes of telephone contact ranged from providing information, to making appointments for home visits, to checking on the family situation. As the family situation stabilized after initial involvement, home visits were reduced and telephone contact generally became the main method of Family Support Worker follow up or continued involvement. Several programs specified the frequency of follow up telephone contacts (usually once or twice a month) but generally it seemed that the individual Family Support Worker used her own judgement on what was appropriate for a family.

c) PROGRAM VISITS - For some cases Family Support Workers visited the child or parent and child in a program placement. Sometimes these visits were done to monitor the placement and see how things were developing. Other times such visits were made to consult with professionals and staff running the program.

d) PARENT GROUPS - Many of the Family Support Worker programs reviewed have established their own parent groups or encouraged their parents to attend groups which were already being conducted. Usually the meetings were on a weekly basis and the Family Support Workers were in attendance in a leadership or facilitating role. The purposes of these groups varied from parent education, to parent skill training, to individual and group counselling seminars. Only one program has used such groups to encourage parent self-help initiatives directed towards organization for more adequate service programs.

Although there was some office contact in all programs (i.e. parent visits to Family Support Worker's office) this form of contact was particularly frequent in one family support Worker program which had a strong counselling orientation of service delivery.

In terms of the time spent in carrying out their activities, most time was spent in client contact, either face to face or by telephone. Often this activity took up 1/4 to 1/3 of the Family Support Worker's time. Approximately the same amount of time was also spent in client-related activity-case recording, case administration, and phoning. The next largest category for time expenditure was agency liaison and contact. Remaining time was spent travelling, doing community development work, paperwork, tracking details of what should be happening with clients, or meeting with supervisors.

E. Work Histories, Training, Salaries

The backgrounds of the Family Support Workers varied greatly from one worker to another. In most organizations hiring was apparently done more on the basis of the individual and her strengths, than insistence on a particular educational/experiental background. One organization (Surrey Place Centre) was an exception to this, and in that case all new staff must have a particular degree and background in public health nursing. All the Family Support Workers were women except for one man who carried a small caseload in addition to supervisory responsibilities. There was a low rate of turnover in the agencies visited, and Family Support Workers tended to be staying at their jobs for a fairly lengthy period of time.

In all cases, a background in mental retardation or working with groups or families was reported by Supervisors or Directors as desirable, as was a knowledge of services and direct service experience. Some agencies felt that an MSW was desirable but were not stringent about this requirement. Across the seven programs reviewed Family Support Workers held various degrees: PHNs, MSWs, mental retardation certificate, B.A. in Family Studies, Psychology and Child Care.

The previous experiences of the Family Support Workers varied tremendously. Many were from positions that involved work directly with children, while fewer had worked with adults or in community-oriented positions. Staff backgrounds included some nursing, psychiatric nursing, day care counsellor, teacher of non-handicapped children, teacher of handicapped children, volunteer in association for the mentally retarded, Social Worker for the Children's Aid Society, Adult Protective Service Worker, and direct service work in institutions. The duration of experience Family Support Workers had in human services ranged from 2-3 years to a number of individuals with 5-10 years' experience. Several people had over ten years experience. The youngest Family Support Workers were 25 years old, although most were over 35.

Salaries varied widely with a difference of $7,000 (annually) from the agency offering the lowest salary to the highest. In some cases salaries were subject to union agreements and they were in line with those of staff doing similar jobs at the host agency. In one case, a Family Support Worker's salary remained for many years near the bottom of the scale because she couldn't earn more than the Executive Director for the agency. There were not any really strong feelings reported that salary ranges were inappropriate.

Most Family Support Workers tended to feel that their own training and experience was appropriate and equipped them well for the job. Regardless of the individual differences between programs, some common characteristics seemed to be a low staff turnover rate and staff with strong background experiences. In general the program appeared to be attracting qualified, competent and dedicated staff.

4. CLIENT CHARACTERISTICS AND CLIENT IMPACT

A. Methodology

Information concerning clients was derived from the following sources: reviews of agency data summaries, review of selected client files, direct client interviews, workers' general descriptions of client. The parent interviews were conducted by telephone and concerned the same clients whose files had been reviewed previously. Some personal interviews with clients were also conducted. Each program was asked to identify fifteen representative clients using their own judgement. The number of clients provided by each agency varied from eight (the entire caseload) to fifteen. A total of eighty-four families were interviewed by the study team, and some of these families included several children 'at risk' or on the Family Support Worker caseload. Agency workers introduced the study to all clients and requested their participation. Confidentiality and anonymity were assured. To our knowledge, no clients refused to participate.

Data on client family characteristics were derived primarily from the interviews rather than agency summary data. It should be noted that in at least one agency studied, the Family Support Worker indicated that the client sample in the study was not representative because of exclusion criteria such as 'no telephone', 'inability to speak English', or 'extremely low functioning that would make interviewing difficult'. For this reason caution is required in extrapolating findings to the total Family Support Program, or even to the total clientele served by the seven programs studied. It should be noted also that agency summaries of client data were generally unavailable. Most programs simply did not have easily retrievable data on Family Support Clients. Consequently, the findings reported here are derived primarily from the interviews with clients and the review of client files.

B. Findings

Although a wide **age range** (item 1, p.34) was served by the seven programs taken together, it should be noted that several programs concentrated their services on fairly narrow age groups. The birth to six-year old level was the range most often served. Family Support Worker Programs with a community/service coordination orientation were much more likely to serve a broad range of clients with respect to age. Programs with an internal/direct service tendency were more likely to serve a restricted age range - supplementing the services of the host organization. Some programs served older children and adolescents and there were examples of twenty and thirty year old clients who were still living with their parents. Where the host agency also included Adult Protective Service Workers, there was a close liaison and good working relations between the APSW and the Family Support Workers. If the client with evidence of developmental delay was being supported by parents, the Family Support Worker would be the primary worker. If such a client were in some form of independent living, the APSW would be the main worker.

The unavailability of data summaries regarding **client sex** required the evaluators to rely on the selected subsample of clients actually interviewed. The same number of males and females occurred in that sample. Similarly, a comprehensive description of the form and **degree of developmental retardation** for clients was systematically available in only one of the seven programs. (Surry Place Centre).

There was no consistent description across the programs sampled of the target client group for whom the Family Support Worker Program was designed. Data from the case reviews (item 4, p.41) indicates that only about half of the clients were identified as mentally retarded or developmentally delayed. The proportion of such clients in each program varied considerably. Based on data derived from interviews and from the information scattered throughout client records:

a) four programs served children and young adults who were mildly or moderately mentally handicapped, occasionally with additional complications (usually behavioural)

b) one program operated by the most specialized agency served clients with moderate and severe levels of retardation and additional developmental handicaps.

c) two programs served clients who had no diagnosis or indication of mental retardation. Their clients were described as being developmentally delayed (e.g. delayed speech or toilet training), or were in danger of experiencing a developmental delay due to inadequate parenting or stimulation in the home.

The latter two programs emphasized a preventive orientation and both were serving low income multiproblem families, many of whom were on some form of welfare assistance. In these programs the parents rather than the child were considered to be the clients.

It should be noted that some programs which were apparently not seeing clients with any degree of mental retardation, were in fact aware of mentally retarded clients in their communities who were on residential waiting lists. (items: 17, p.32/3, p.34).

The findings indicated that the nature and philosophy of the host organization has a major impact on the Family Support Program - here, with respect to client families served. Programs with a community/service coordination orientation dealt with a broader range of clients in terms of income and educational level, than programs with an internal/direct service focus. However, even within these (somewhat) arbitrary categories of programs, there is considerable diversity. One 'coordinating program' contained only one example of a welfare client in

its study sample. Other 'coordinating' agencies had a distribution of client income that is more representative of the general population. Programs with a direct service orientation were serving clients who were primarily at the low end of the income (welfare or marginally employed) and educational spectrum. These programs also had more clients who were new immigrants and non-English speaking. Also, a number of the parents in these programs were themselves identified as mentally handicapped or developmentally delayed (in at least eleven families or about 10% of the sample interviewed).

The primary client care giver was in most cases the natural parents, although about a third of the sample were single parents with a few of these being single fathers. Several grandparents were also being helped by the Family Support Worker.

C. Client Impact

The client impact component of this study was obtained from interviews with clients, agency workers and Family Support Workers, as well as data available in the client file (items: 3-15, pp. 26-31/7, p.36/9-14 pp.37-39/5-10, pp.41-46). As described above, the clients interviewed may not be representative of clients in all Family Support Worker programs, or even of all clients in the seven programs involved in the study.

Impact issues were not to be a major focus of the study so the findings reported here must be considered as trends observed and not as conclusive results.

With respect to **client satisfaction** the vast majority (93%) of clients were generally satisfied with the Worker and the services she was providing. This finding holds for programs which provided direct service and programs which coordinated services. Clients generally expressed appreciation for the accessibility of the Family support Worker, for demonstration of personal support and commitment, and for the amount of time she provided to the client especially in crisis situations (item 6, p.35). Again, this finding holds for both direct service and service coordination type programs.

Several parents indicated they felt more personal support from the Family Support Worker than from other case workers. Most clients (73%) identified the Family Support Worker as the first professional contact they would make if they had a concern about the service they were receiving, if a new problem arose, or if a crisis developed. These positive reactions to the family Support Worker may very well relate to the Workers' descriptions of their own role as providers of whatever family support services the client requires - from a basic instrumental service (e.g. chauffering), to emotional support and counselling in time of crisis.

Despite their generally positive reactions to Family Support Workers, clients did not have a clear concept of the workers' role and mandate. Clients described a wide variety of specific activities/services provided by the worker when asked about the worker's role (items 1 & 2, p.24) They did not have a clear view of the Family Support Worker as a case coordinator. This holds true even for those programs which have the most pronounced orientation in this direction. The wide variety of specific services provided or arranged by the worker may, in fact, contribute to this role ambiguity in the client's eyes. Clients are more familiar with service providers who have a fairly restricted mandate. The uniqueness of the Family Support Worker's role in providing/arranging whatever support services the situation requires may need furtrher clarification.

Several parents remarked on improvements in their children or themselves as a result of the Family Support Worker's involvement.

The majority of families were concerned with immediate and short-term issues in their dealings with Family Support Workers. Stabilization of a difficult or crisis situation was a common Family Support Worker contribution for families. There were very few examples, from any source, of the workers and clients engaging in long-term planning or goal setting. The vast majority of parents were generally unaware of the Individualized Program Plans used by the Family Support Workers, and the IPP's rarely reflected any long-term plans. Parents seemed to feel a long-term commitment on the part of the workers, and the workers certainly conveyed such a commitment to families. However, this general long-term commitment was not reflected in the actual planning process. Planning for the family was the area most frequently cited by the family for the Family Support Worker to concentrate on in the future (item 13, p.29).

Finding alternative residential placement for children was a major concern for many of the programs. Client files indicated twenty seven instances where the Family Support Worker identified the need for an alternative placement and assisted in arranging the placement. Not in all cases, however, were community residential alternatives arranged. About a third of the placements were in traditional institutional settings. There were also some examples reported by Family Support Workers in other agencies and from families themselves, of alternative residential placements being prevented through the services of the Family Support Worker.

When a child did enter alternative care, the Family Support Worker's continued involvement with the case was dependent on whether the placement was seen as a semi-permanent one, or whether it was to be short term. If the placement was short term, the Family Support Worker was more likely to remain involved. There is not an explicit or consistent policy regarding this issue across the programs studied.

The seven family support programs studied **have clearly increased the services available to children** in their area. However, the manner and extent to which they have done so varies considerably from program to program. One program with a strong service coordination orientation was the only program to close cases because the clients were identified as capable of managing their own service requirements. These clients might still have been receiving services in the community, but the case managers from the Family Support Program were no longer needed. Clients had been assisted in the past, and had learned how to search out, identify and approach various agencies and community services to meet their own needs. Some minimal, information contact with the Family Support Worker might be retained, and clients knew they could recontact the worker if the need arose.

Although these examples were by far the exception, they are worth noting. The program with the strongest service coordination orientation felt that more examples like this would become evident in the future as more clients learned to be their own case managers. The same program also had a strong sense of minimizing client dependency on their services.

Programs with a service coordination orientation not only facilitated accessibility to a wide range of community resources (both generic and specialized), but they also played some role in developing new services once gaps were identified. While there are only a handful of examples of this type of service development across the seven programs, it is worth noting that they all occurred through programs with a service coordination orientation. Although advocacy was not a strong component of these seven programs, the programs which tended to have a stronger sense of client advocacy were the service coordination types.

The direct service type of family support program increased the amount of services offered to clients quite directly. Clients in these programs generally had multiple needs and almost anything the family support workers delivered made an important contribution to that family and its ability to provide for its children. Case closures in these types of programs were either non-existent (some programs had no provisions for closure), or were based on client moving or a child entering a long-term placement. The issue of client dependency was less of a concern in these programs than in the service coordination-type programs.

5. IMPACT ON SERVICE COORDINATION

This evaluation of the Family support Worker Program has already detailed the wide variations in roles and functions performed by the workers, and the focus and type of host organization have been identified as the key contributors to variation. The basic characteristics of service coordination have also been described (p. 12). Those Family Support Worker programs which were found to be concerned primarily with 'in house' direct service delivery were not engaged in coordination as described above. This was true

in large measure for nearly half the sample programs studied. Regarding service coordination functions, some were concerned primarily with coordination within their own large multiservice organizations, and consequently their use of generic community programs was negligible. The several Family Support Worker programs with an external community focus and only limited program potential, were involved in service delivery coordination and were most likely to encourage and use generic services. In a few cases programs that identified clients as 'at risk' or 'developmentally delayed' tended to utilize internal generic services like welfare workers or homemakers rather than more specialized services. Across the sample of programs a range of services were observed being coordinated, for example babysitting and parent relief, transportation, homemaking, infant stimulation and parent effectiveness training, residential and vocational services (item 2, p.24). There were several examples noted of the community focused agencies actually helping develop new services or integrate existing services to provide for mentally handicapped clients. It has been reported above (3. The Family Support Workers, p. 13) that while service delivery coordination was frequently mentioned by Family Support Workers as a key component of their role, client interviews, related agency interviews, and file documentation did not support this perception in many cases. It is interesting to note that many community agency workers looked to the Family Support Workers for more planning (60%) and coordination (49%) in the future (item 16, p.48).

The one hundred community agency interviews were overwhelmingly positive and supportive toward the Family Support Worker program (items 8-15, pp.43-47). However either because of the 'newness' of the program or limited contacts with the worker, these related agency workers did not report much impact by Family Support Workers on their own agencies' policies and programs and their description of the Family Support Worker's role centered around terms like 'family support'. Of the roles officially established by the Ministry, 'case coordination' was only sometimes identified, and very occasionally 'diagnosis'. When the possible roles for the Family Support Workers were read out to agency workers they usually reported all of them as valid, although they did not identify them on their own. Confusion about roles was greatest where Family Support Worker programs were delivering a lot of direct services.

The sample Family Support Worker programs demonstrated an active presence in their M/R District Working Group, either by the actual membership of the Worker, Supervisor, or Director, or by another mechanism for input. This presence had impact in several cases on services to mentally retarded clients, notably in one case, on a non-generic service provider's intake policy regarding residential care for mentally handicapped children over sixteen years of age. However, both local Associations for the Mentally Retarded and District Working Groups are predominantly concerned with the planning and coordination of services to only mentally retarded clients. Their concern with, or ability to coordinate generic services in their communities is limited. To this extent the Family Support Worker Program has had limited ability to impact comprehensive service delivery coordination through these groups.

V. FOOTNOTES

(1) Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario: Walter B. Williston, Q.C., August 1971.

(2) Community Living for the Mentally Retarded in Ontario: A New Policy Focus: Hon. Robert Welch, Q.C., LL.D., Provincial Secretary for Social Development, March, 1973.

(3) Community Services for the Mentally Retarded: Detailed Program Proposal and Implementation Plan; Ministry of Community and Social Services, April 17, 1975; p.37.

(4) Mississauga, Brampton/Caledon, York Centre, Sutton, Newmarket.

(5) Key Elements of a Family Support/Case Management Model, The Applied Research Consulting House Ltd., prepared for the Ministry of Community and Social Services, January, 1982.

(6) Analysis and Summary of the Metropolitan Toronto Family Support Worker Program; Faith Mills, Program Supervisor, Ministry of Community and Social Services, 1980.

(7) Family Support worker Program Description; Ministry of Community and Social Services, Community Resources Branch; 1977, 2 pages.

(8) Community Services for the Mentally Retarded: Detailed Program Proposal and Implementation Plan; Ministry of Community and Social Services, April 17, 1975.

APPENDIX 1

CLIENT SURVEY
(N=84)

1. What is your understanding regarding how the FSW is supposed to assist you? (Please indicate if the following are/are not clearly identified.)

%	N	
21	18	getting a comprehensive assessment completed
27	23	developing an individualized plan for services
29	24	assuring/co-ordinating the required services
27	23	following up to ensure that the services provided are what is needed
30	25	identifying new needs and service resources over time
29	24	other (specify)*
25	21	unclear, dont know

*Other

support family	7	family advocacy	2
child training	7	transportation	2
information	5	parent-teacher help	1
problem solving	4	outings with child	1

2. What kinds of service does the FSW provide?

	Child Focus	Family Focus	
	N	N	%
Direct Service	38	71	46
Support Service	76	52	54

2. Kinds of Service (Cont'd)

a) Direct Service:

N	Child Focus	N	Family focus
11	transportation	20	emotional support, discuss problems
8	counselling	12	transportation
5	teach skills to child	11	counselling
5	visit child	7	parent training group meetings
3	direct advocacy	6	parent education seminars
1	outings	6	parent training
1	get clothing	5	financial help
1	sex education	2	advocate
1	assessment	1	outings with family
		1	shopping
		1	find housing

b) Support Services:

N	Child Focus	N	Family focus
11	co-ordination, referral	13	Arrange for parent relief
11	assessment	10	provide information
8	locate behaviour management programs	10	arrange for housing
7	locate recreation programs	6	arrange for financial help
4	locate infant stimulation	4	arrange for planning
4	locate vocational services	3	arrange for referral
3	locate school help	3	arrange for liaison
3	locate camp	1	arrange for counselling
3	locate day care	1	arrange for employment
2	locate night school	1	arrange for food
2	locate well-baby clinic	1	arrange for legal assistance
1	accompany mother to court	1	arrange for transportation
1	locate residential services		
1	locate homemaker, volunteer		
1	sex education		
1	physiotherapy		

3. **Have you made requests to your FSW which have not been met?**

N	%	
10	12	yes
62	74	No
12	14	No Answer

4. **Does your FSW explain what he (she) is trying to do for you?**

N	%	
66	79	Almost Always
12	14	Mostly
1	1	Only Sometimes
1	1	Rarely
4	5	No Answer

5. **Does your FSW try to find out what you would like before making arrangements for getting you services?**

N	%	
67	80	Almost Always
8	10	Mostly
2	2	Only Sometimes
2	2	Rarely
2	6	No answer

6. **Does your FSW involve your child (to the degree he/she is able to in the participate) decision of what services are required?**

N	%	
18	22	Almost Always
5	6	Mostly
6	7	Only Sometimes
7	8	Rarely
48	57	Not Applicable

7. How satisfied are you with how quickly your FSW responds to your child?

N	%	
69	82	Very satisfied
8	10	Somewhat satisfied
1	1	Somewhat dissatisfied
2	2	Very dissatisfied
4	5	Don't know

8. How satisfied are you with how quickly your FSW gets things going for you?

N	%	
66	79	Very satisfied
9	10	Somewhat satisfied
1	1	Somewhat dissatisfied
3	4	Very dissatisfied
5	6	don't know

9. How satisfied are you with the quality of service your FSW provides to you?

N	%	
70	83	Very satisfied
5	6	Somewat satisfied
3	4	Somewhat dissatisfied
1	1	Very dissatisfied
5	6	No answer

10. How satisfied are you with the suitability of agencies recommended by your FSW?

N	%	
43	51	Very satisfied
16	19	Somewhat satisfied
3	4	Somewhat dissatisfied
6	7	Very satisfied
16	19	No answer

11. How satisfied are you with the attitude of your FSW?

N	%	
78	93	Very satisfied
3	4	Somewhat satisfied
1	1	Somewhat dissatisfied
1	1	Very dissatisfied
1	1	No answer

12. How satisfied are you with the overall services provided by your FSW?

N	%	
71	85	Very satisfied
8	9	Somewhat satisfied
1	1	Somewhat dissatisfied
1	1	Very dissatisfied
3	4	No answer

13. For the future, in which of the following areas do you think the FSW program should concentrate its efforts?

N	%	
48	57	planning for the family
44	52	co-ordinating services
26	31	providing direct services (other than referring) (i.e. parent training, working with child, parent relief, transportation)
38	45	referring to other agencies
32	38	offerring family counselling
37	44	offering counselling to the family member
34	40	educating the public about the developmentally handicapped
22	26	developing new services
10	12	other (i.e. integration in schools, "a friend", follow-up, keep in contact)
10	12	No answer

14. PLEASE SEE NEXT PAGE (due to spacing situation)

15. Has the FSW shown you how to obtain the services that you and your child need on your own (i.e. without FSW help)?

N	%	
31	37	Yes
46	55	No
7	8	No Answer

14. **I will now identify a number of services which various families often request. For each one, please indicate how helpful FSW services have been assisting you in meeting your needs.**

		Very Helpful	Somewhat Helpful	Not Too Helpful	Not At all Helpful	Have Not Used This Type of Help	% Requesting A Sevice
a)	Assist with problems in school, changing schools, or other related matters	23	8	1	2	48	41
b)	assist with parent relief	28	3	-	4	47	43
c)	assist with day care facilities	11	3	2	-	65	20
d)	assist with sheltered workshop experiences	7	2	-	-	72	11
e)	assist with clinical assessment - I.Q. testing, speech and hearing tests, etc.	33	4	-	-	43	46
f)	assist with recreation facilities	15	4	2	2	59	28
g)	assist with summer camp	15	3	-	-	63	22
h)	assist with vocational program	5	3	-	-	76	10

		Very Helpful	Somewhat Helpful	Not Too Helpful	Not At all Helpful	Have Not Used This Type of Help	% Requesting A Sevice
i)	assist with service to help in managing a child's behavior	25	10	-	-	47	43
j)	assist with facilities for infant stimulation	8	1	-	1	71	12
k)	assist with suitable employment	1	-	-	-	82	1
l)	assist with resources for multiple handicapped persons	3	1	-	-	79	5
m)	assist with suitable nursery programs	10	3	-	1	67	17
n)	assist with specialized medical services	9	4	-	1	68	17
o)	assist with residential services	6	2	-	1	45	17 (not all asked)

16. If you feel you need new or different services for your child, what would you do?

N	%	
10	12	seek services on my own
4	5	go to family doctor
-	-	go to AMR
61	73	go to FSW
-	-	go to PHN
1	1	go to program where I am now getting service
6	7	other (specify - depends on situation, teacher, church, CAS, discussion group, other parents
3	4	don't know

17. Family Characteristics

a) Marital Status:

N	%	
60	71	Married
23	28	single parent
1	1	no answer

b) Total number of children:

52% families had 1-2 children
42% families had 3-5 children

c) Total number of children receiving care:

93% families had one child in special care

d) Source of support:

N	%	
57	68	employment
13	15	Welfare
14	17	Other*

*Other - mother's allowance, UIC, alimony, family benefits.

17. (cont'd)

e)

Mother's Education	Father's Education	
N	N	
2	1	less than grade school
26	22	grade school
33	27	high school
15	9	college/university
3	8	graduate work
3	4	no answer, don't know

f) Total Family Income: Would you please indicate which letter corresponds to your total family income?

N	%	
26	31	A Under $10,000
13	15	B $10,001 - $15,000
10	12	C $15,001 - $20,000
17	20	D $20,001 - $25,000
5	6	E $25,001 - $30,000
10	12	F $30,000 +
3	4	H Dont know

APPENDIX 2

CLIENT/CASE DESCRIPTION (N=93)

Files of 93 families were reviewed, most corresponding with clients interviewed. However, some clients whose files were reviewed could not be reached for interviews.

There were a total of 112 clients accounted for in case files.

1.

Age	0-2	3-5	6-8	9-11	12-14	15-17	18+
N	15	29	12	8	11	8	29
%	13	26	11	7	10	7	26

2.

Sex	Female	Male
N	56	56

3. Is one or both parents retarded?

N	
11	Yes
64	No
18	No indication in file

4. Diagnosis: (in many instances, more than one handicap was noted.)

a)

Mental Retardation/Developmental Disability	N
mild mental retardation	25
mental retardation (degree unspecified)	13
moderate mental retardation	11
Down's Syndrome	6
developmental delay	5
severe mental retardation	4
autism	3
brain damage	2
learning disability	1

b)	Physical and Related Handicaps	N
	cerebral palsy	12
	speech problems	10
	epilepsy	9
	motor problems	4
	visual problems	1

c)	Other	N
	behaviour problems	20
	health problems	4
	failure to thrive	1
	at risk	1
	allergies	1

d)	diagnosis absent	9

5. Status of Cases Reviewed

	N
active (Many unclear)	78
follow-up	7
closed	8

6. Duration of FSW involvement

	N
0-10 months	36
11-15	9
16-20	17
21-25	17
26+	14

7. Workers' Individual Program Plan:

a) Parent Focus	N
monitor emotional support to parents	52
family counselling	13
information to parents	5
encourage parents to be active in support group	3
marriage counselling	3
parent help	2
help father keep children	1

b) Service Location or Provision	N
find services	33
assessment	14
residential placement	14
parent relief	9
school related	8
finance and housing	6
behavioour management	4
find volunteers	3
nutrition assistance	2
assistance to overcome physical problems	1
provide information on integrated day care	1
transportation	1
sex education	1
advocacy	1

c) Co-ordination Roles	N
coordination, liaison	15
planning	1

d) I.P.P. absent 16

8. Who was involved in developing IPPs?

In 73 files, only the FSW was involved in developing the IPP.
In 16 files, there was no IPP.

9. Services Identified in Files: As being required and provided (some clients required/received more than one service).

a) Service	N	Service	N
residential	27	special equipment	3
counselling, help with family problems	20	extend-a-family	2
camp, recreational, social	20	sex counselling	2
		parenting skills	2
parent relief	19	transportation	2
behaviour management	17	legal help	2
financial assistance/ budgeting	12	day treatment	2
day care	11	physiotherapy	1
vocational services	10	occupational therapy	1
assessment	10	toy library	1
volunteer	6	homemaker	1
speech therapy	6	sibling counselling	1
infant stimulation	5	genetic counselling	1
school	5	psychiatric consultation	1
medical	3	discussion group	1
housing	3		

b) Services identified as required, but NOT provided:

	N		N
residential services	9	counselling	1
parent relief	3	vocational programs	1
integrated school	3	nursery school	1
camp, recreational program	3	volunteer help	1
speech therapy	2	behaviour management	1
housing	1	special equipment	1
life skills	1	educational program	1

10. **Method of Ongoing Case Review:** A review of files revealed that there were no consistent methods of case review. In some situations, it appeared that case conferences were used to review cases, but these did not occur often (see #12 below)

11. **Consequences of Case Review:** Review of files did not provide information on this issue

12. **FSW Co-ordination Activities:** A review of case files indicated the following types of co-ordination activities occurred.

	N		N
non-specified agency conatact	58	arrange assessment	4
identify resources	18	arrange programs	4
arrange meetings/conferences	14	perform assessments	4
Follow-up	14	co-ordination with	
referral	10	agency	1
collect background information on families	9		

13. F.S.W. Role: File review reveal family supports in the following roles.

	N
emotional support to parents	32
counselling	17
co-ordination	17
direct service	13
advocacy	6
help parents organize group	3
link parents to support group	3
assessment	3
transportation	4
help start program	2
obtain legal advice	1
toilet training	1
develop contract with client	1

14. General condition of Files:

- Some files were very extensive and complete
- many had no progress notes, but did have periodic summary notes
- some had no IPPs, or very old IPPs
- some files were incomplete

- Some had case management notes and other program notes (i.e. bahaviour management notes) together in some instances, and it was hard to tell if the client was the parent, child, or if several children were clients.

3. What is your understanding of what the FSW is supposed to do?

N		N	
35	case coordination	9	case evaluation
30	emotional support to families	7	advocate
16	identify and locate resources	4	referral
13	direct service roles	4	liaison
11	identify gaps in service	1	facilitate internal services
10	diagnose and assess	1	follow-up
9	develop IPPs	14	not clear on role

4. Does the FSW deal with your agency in a predictable way?

N	
75	Yes
17	No
8	Don't Know

5. What, if any impact have the FSWs had on your agency and the way you operate?

N	
63	Yes, Impact
35	No Impact
2	No Answer

Comments: Most workers indicated that the FSW's impact was primarily on their clients, rather than on the procedures and policies of their agency.

APPENDIX 3

COMMUNITY AGENCY SURVEY
(N=100)

1. **Type of agency interviewed** (some agencies provided more than one type of service).

N		N	
27	social service	20	M.R. Service
26	educational	11	employment/vocational
21	Other*	6	recreational

* Other

N		N	
2	public health	1	community health
2	occupational therapt	1	infant development
2	residential	1	assessment
2	speech therapy	1	Children's Aid
1	family benefits	1	another FSW
1	Crippled Children's service	1	family relief
1	medical	1	mental health
1	psychiatric out-parient	1	extend-a-family

2. **Do you typically make referrals to the FSW?**

N	
54	Yes
18	No

Or receive referrals from them?

N	
62	Yes
20	No
12	No Answer (Some agencies did both)

5. (Cont'd)

Types of impact:

N		N	
11	helps families	1	trouble shooting and advocacy
7	referrals	1	providing alternatives for client
6	helps agency to know services	1	prevent institutionalization
4	liaison	1	increased workland
2	mutually supportave	1	made agency rethink unwritten policies
2	additional resource	1	adapt program with FSW advice
2	improve client behaviour	1	take family pressure off agencies
1	understanding potential of handicapped children	5	Don't Know
		58	No comment

6. **What do you see as the FSW's primary responsibility in the cases you are both involved in?**

N		N	
23	support the family	3	provide information (to agencies)
13	advise parents	3	goal setting and planning
13	case coordination	2	prevent child abuse
12	find services	2	problem solving
8	liaison between agency and home	2	counselling
7	follow-up	2	no answer
7	help parents learn skills	1	initiate contact with families
4	assessment	1	direct service

7. What do you see as the FSW's authority regarding decisions about cases you are both involved in?

N & %	N & %
37 None	4 only in home
30 shared	4 don't know
11 limited	10 other answer
4 much	

8. Has the presence of an FSW program helped or hindered your delivery of service?

N	%
81	87 helped
4	4 hindered
7	8 neither
1	1 don't know

If there was no FSW, who would do what they do now?

N	
16	don't know
20	no one
26	responding agency
30	another agency (PHN, CAS, APSW, SPC)
1	parents

What happened before FSW program?

N	
31	don't know
15	no one
14	responding agency
24	another agency (AMR, SPC, CAS, social workers, PHN, APSW)

9. How easy is it to obtain assistance from a Family Support Worker?

N & %	
61	very easy
16	somewhat easy
3	somewhat difficult
1	very difficult
19	no response

10. PLEASE SEE NEXT PAGE (due to spacing situation)

11. How satisfied are you with the time the FSW takes to respond to your needs?

N & %	
77	very satisfied
8	somewhat satisfied
1	somewhat dissatisfied
2	very dissatisfied
12	don't know

12. How satisfied are you with the quality of the FSW's services?

N & %	
73	very satisfied
7	somewhat satisfied
1	somewhat dissatisfied
2	very dissatisfied
17	don't know

10. I will now identify a variety of services which various clients may require. For each one, indicate how <u>helpful</u> FSW services have been in assisting you in meeting your (clients') needs.

		Very <u>Helpful</u>	Somewhat <u>Helpful</u>	Not Too <u>Helpful</u>	Not At all <u>Helpful</u>	Have Not Used <u>This Type of Help</u>	% Requesting <u>A Sevice</u>
a)	Assist with problems in school, changing schools, or other related matters	17	8	1	-	71	27
b)	assist with parent relief	32	7	-	1	57	41
c)	assist with day care facilities	15	4	-	-	78	20
d)	assist with sheltered workshop experiences	16	6	-	-	75	23
e)	assist with clinical assessment - I.Q. testing, speech and hearing tests, etc.	37	9	-	-	51	47
f)	assist with recreation facilities	26	5	-	2	66	32
g)	assist with summer camp	15	1	-	-	81	16
h)	assist with vocational program	16	4	-	-	77	21

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not At all Helpful	Have Not Used This Type of Help	% Requesting A Sevice
i) assist with service to help in managing a child's behavior	29	12	2	-	54	44
j) assist with facilities for infant stimulation	5	2	-	1	90	7
k) assist with suitable employment	6	2	-	-	89	8
l) assist with multiple handicapped persons	16	6	-	-	74	23
m) assist with suitable nursery programs	7	6	-	-	84	13
n) assist with specialized medical services	17	5	-	-	75	23
o) assist with residential services	14	4	-	-	50	19 (not all asked)

13. How satisfied are you with the suitability of the agencies recommended by the FSW Services?

N & %	
42	very satisfied
18	somewhat satisfied
3	somewhat dissatisfied
0	very dissatisfied
37	don't know

14. How satisfied are you with the attitude of the FSW?

N & %	
86	very satisfied
5	somewhat satisfied
1	somewhat dissatisfied
0	very dissatisfied
8	don't know

15. How satisfied are you with the overall service provided by the FSW program?

N & %	
69	very satisfied
14	somewhat satisfied
1	somewhat dissatisfied
1	very dissatisfied
15	don't know

16. For the future, in which of the following areas do you think the FSW program should concentrate its efforts?

N & %	
60	planning with the family
49	coordinating services for the mentally retarded
41	providing direct services (other than referring)
39	referring to other agencies
38	offering family counselling
34	offering counselling to the handicapped family member
28	educating the public about mental retardation
25	developing new services
12	other (parent relief, advocacy, needs identification, crisis intervention, make information available to agencies)

17. Are there any other comments you would like to make about the FSW program? What would you suggest to make the program even better?

N	
24	more publicity
14	more FSWs (expand program)
11	program provides good service now
7	program sould be generic
7	stronger, clearer mandate
4	lack of continuity, staff turnover
3	service duplication
1	too much bureaucracy
1	avoid direct service
1	program should do counselling